

# **FINANCIAL AGREEMENT**

## **METROPOLITAN DENTAL CENTRE**

*The Center for Comprehensive Dentistry*

**10509 B Braddock Road**

**Fairfax, Virginia 22032**

**(703)503-5031**

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that as a patient, parent, guardian or personal representative, I am responsible for all fees and services rendered. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. Insurance claims are filed by this office as a courtesy and payment will be made directly to the patient. Accounts over 90 days will have a 10% rate applied.

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Signature of patient, parent, guardian or personal representative

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Date

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print name of patient, parent, guardian or personal representative

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date